



REFERRAL FORM

DATE OF REFERRAL:

____ / ____ / ____
M D Y

Please return to: The Buddy Program, Inc.
P.O. Box 617, Basalt, CO 81621 Fax: 970-927-0193 **OR**
110 East Hallam Street, Suite 125, Aspen, CO 81611 Fax: 970-925-2093

OR email: lindsayl@buddyprogram.org
This form can also be found at: www.buddyprogram.org

When filling out this form, please be as thorough as possible. This is a confidential form.

Please check the appropriate program:

Community School-based Peer-to-peer Group/Experiential

CHILD'S NAME: (first, last)		SEX: <input type="checkbox"/> Male <input type="checkbox"/> Female		DATE OF BIRTH: (M/D/Y)		AGE:	
PHYSICAL ADDRESS:			MAILING ADDRESS:			COUNTY (WHERE YOU LIVE):	COUNTY (WHERE YOU WORK):

NAME OF PRIMARY PARENT:		WORK PHONE:		HOME PHONE:		CELL PHONE:	
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PARENT'S EMAIL ADDRESS:				CHILD'S EMAIL ADDRESS:			
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DOES THE CHILD SPEAK ENGLISH? <input type="checkbox"/> Yes <input type="checkbox"/> No				DOES THE PARENT SPEAK ENGLISH? <input type="checkbox"/> Yes <input type="checkbox"/> No			
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REFERRING PERSON AND/OR AGENCY

NAME:			PHONE:			EMAIL:		
SCHOOL:			GRADE:	PHONE:			FAX:	
TEACHER:				COUNSELOR:				
OTHER AGENCIES INVOLVED WITH CHILD/FAMILY:				CONTACT PERSON:			PHONE:	

REASON FOR REFERRAL

(check all that apply for to this child and his/her family)

Physical Abuse	Emotional Abuse	Sexual Abuse
Neglect	Lack of Supervision	Behavioral Issues
Drug/Alcohol Use (by child)	Drug/Alcohol Use (by parent)	ADD
Divorce	Death of Parent	Domestic Violence
Attendance	New Student	Child's Desire
Parent in Prison/ Trouble with Law	ADHD	At-risk of Out-of-Home Placement
Only Child	Adopted	Single Parent

Needs Companionship		Family Crisis(please specify):	
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Mental Health Needs(please specify):		Developmental Disability (please specify):	
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Other (please explain):

Please describe child's personality (include strengths & challenges):

Please describe successful strategies used with this child: